



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

BAYLOR SURGICARE AT MANSFIELD

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-17-0252-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

SEPTEMBER 30, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was not paid according to the 2016 Texas Ambulatory Surgical Center Fee Schedule or guidelines for payment of implants used in this procedure."

Amount in Dispute: \$3,902.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs and the reduction rationale(s) stated therein...the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 25, 2016	Ambulatory Surgical Care for HCPCS Code L8687 plus Interest	\$3,902.82	\$7,177.85

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. Texas Labor Code 413.011(b) provides for additions or exceptions to the Medicare policies.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.

- 309-The charge for this procedure exceeds the fee schedule allowance.
- 954-The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance.
- W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for HCPCS code L8687?

Findings

On the disputed date of service, the requestor billed CPT codes 63685, and L8687. The respondents paid for codes 63685 and is not in dispute. The respondent reduced payment for code L8687 based upon reason codes "P12" and "309."

HCPCS code L8687 is defined as "Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension."

28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

The Division reviewed the submitted medical bill and finds that the requestor did request separate reimbursement for the implantables; therefore, the disputed services were applicable to the reimbursement methodology outlined in 28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii)."

28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

A review of the submitted documentation finds that the requestor submitted a copy of invoice from Boston Scientific that lists the total cost of implantables as \$33,194.00.

28 Texas Administrative Code §134.402(b)(5) states "Implantable" means an object or device that is surgically:

- (A) implanted,
- (B) embedded,
- (C) inserted,
- (D) or otherwise applied, and
- (E) related equipment necessary to operate, program, and recharge the implantable."

The Division reviewed the invoices and finds the MAR for the following implantables:

Description of Implant	Unit Price	MAR
Precision Spectra IPG Kit	\$28,285.00	$\$28,285.00 + \$1,000.00 = \$29,285.00$
Precision Spectra Remote Control Kit	\$1,790.00	$\$1,790.00 + \$179.00 = \$1,969.00$
Precision Charging System	\$3,119.00	$\$3,119.00 + \$311.90 = \$3,430.90$

TOTAL	\$33,194.00	\$34,684.90
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The total due for implantables is \$34,684.90. The respondent paid \$27,507.05. The difference between amount paid and due is \$7,179.85.

28 Texas Administrative Code §134.402(e) states, "Regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any reimbursement for implantables."

Neither party to the dispute submitted documentation to support that the disputed services were subject to a specific fee schedule set in a contract; therefore, 28 Texas Administrative Code §134.402(e)(2) applies to the disputed services. As a result, \$7,177.85 is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$7,177.85.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$7,177.85 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	10/31/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.